Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005012	A. BUILDING: _____ B. WING _____	09/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT JOSEPH REGIONAL MEDICAL CENTER	5215 HOLY CROSS PKWY MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit is for a State hospital complaint investigation. Complaint: #IN00121277 Unsubstantiated -lack of sufficient evidence. Survey Date: 09/03/13 Facility #: 005012 Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor Saint Joseph Regional Medical Center is in compliance with 410 IAC 15-1.5-10, Utilization Review and Discharge Planning, Indiana Hospital Licensure Rules. QA: claughlin 09/10/13	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE